selection of particular groups of patients. However, the present results can be seen as a basis for discussion about the very restrictive practice regarding decisions on reinbursability of bariatric procedures. Further more, comprehensive quality assurance is needed, including the implementation of competence centres and the fixing of minimum amounts for procedures. In this context the long term assessment and evaluation of all patients and their course of disease is necessary, aiming at the highest possible effectiveness of medical treatment and still allowing for economic limits.

PSY20

THE COST EFFECTIVENESS OF DULOXETINE IN THE TREATMENT OF FIBROMYALGIA IN THE NHS IN SCOTLAND

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OBJECTIVES: The aim of this research was to evaluate the cost-effectiveness of duloxetine as an additional treatment option in the management of fibromyalgia (FM), assessed from an NHS Scotland health care system perspective. **METHODS:** We used a 3-year health state transition model to represent the sequential drug management of patients with FM. Guidelines, evidence reviews and clinical opinion were used to define a standard treatment for Scotland based on tricyclic antidepressants (TCAs) with switching to second-generation antidepressants (SSRIs or SNRIs). The model considered two levels of pain response based on an 11-point severity scale (0 = 'no pain' to 10 = 'worst pain possible'): ≥30% (response) and ≥50% (full response) change from baseline score. Clinical efficacy and discontinuation data were taken from a systematic literature review and an adjusted indirect meta-analysis based on placebo-controlled trials of FM treatments. Utility data were linked to pain severity using trial-based EQ-5D data collected from patients in the duloxetine studies. Costing was based on 2006. Annual discounting was applied equally at 3.5%. **RESULTS:** The first-line use of duloxetine resulted in approximately 67 additional quality-adjusted life years (QALYs) per 1000 patients, achieved at an additional cost of £397,360. This corresponded to a cost per QALY of £5950 compared to current standard treatment without duloxetine. These results were robust to both deterministic and probabilistic sensitivity analyses, demonstrating a 70% probability of the ICER falling below £15,000 per QALY. A step-wise analysis reported a cost per QALY of £4847 for first-line duloxetine versus second-line treatment and £7360 versus third-line treatment. **CONCLUSIONS:** There is currently a significant unmet need for patients with poorly controlled FM where pain is a predominant symptom. These analyses show that the introduction of duloxetine into the standard treatment sequence for FM could provide additional patient benefits which should be considered cost-effective when compared to commonly adopted thresholds.

PSY21

COST-MINIMIZATION ANALYSIS OF ORAL VS. INTRAVENOUS FLUDARABINE (BENEFLUR®) IN SPAIN

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OBJECTIVES: Beneflur®, whose active principle is fludarabine, has an oral and an intravenous (i.v.) formulation. The objective of the present study was to compare the efficiency of both formulations by means of a cost-minimization analysis in the treatment of B-cell chronic lymphocytic leukaemia (CLL) in Spain. **METHODS:** Existence of previous clinical evidence on the therapeutic equivalence between both fludarabine formulations justified a cost-minimization analysis to compare efficiency. The National Health System (NHS) perspective was taken including only direct costs. Also indirect costs were considered allowing a societal viewpoint. Data on resources use were obtained from published literature and through an expert panel. Unit costs were obtained from Spanish costs databases. Generic i.v. fludarabine cost was used. The model was built in Microsoft Excel and a sensitivity analysis by means of two different techniques (scenario analysis and Monte-Carlo Simulation) was performed to ensure robustness of results. **RESULTS:** Although acquisition costs for oral fludarabine are higher than for i.v. fludarabine, higher administration costs for the i.v. formulation due to hospital administration and adverse event costs compensate them, resulting in net savings for the NHS of €2152 and €1322 using the oral formulation (baseline scenario), in monotherapy and in combined therapy respectively. The range of savings obtained through the scenario analysis was: ≥€1024 ≤€3280 for monotherapy and ≥€617 ≤€2027 for combined therapy. Indirect costs, i.e. lost productivity, charge only i.v. fludarabine, adding extra savings to the oral formulation. Monte-Carlo results confirmed model robustness. **CONCLUSIONS:** Oral fludarabine has equivalent efficacy and an improved safety profile than intravenous fludarabine showing total lower costs both in monotherapy and in combination with cyclophosphamide, from the perspective of the National Health System in Spain. Hence, oral fludarabine should be administered instead of intravenous fludarabine unless contra-indicated.

PSY22

PROCESS STUDY: A 6-MONTHS COST-CONSEQUENCE ANALYSIS IN CHRONIC PAIN FROM THE SPANISH PERSPECTIVE

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OBJECTIVES: Chronic back and leg pain results in patients' loss of function, reduced QoL and increased societal costs. The objective was to assess health-related QoL (HRQoL) and health resource utilization in failed back surgery syndrome patients. A comparison of spinal cord stimulation plus non-surgical conventional medical management (SCS group) versus non-surgical conventional medical management alone (CMM group) was made from the Spanish National Health System. **METHODS:** The PROCESS study has been used as data source (Kumar 2007, Manca 2008). 100 patients from 12 European, Canadian and Australian hospitals (1 Spanish: Sant Pau Hospital, Barcelona), were randomised to either the SCS or CMM group. Health care resource consumption data, the implantable generator use in SCS patients, hospital stay, and drug/non-drug pain-related treatment were collected prospectively. Resource consumption costs were obtained from local databases (eSalud and portalfarma databases) using Spanish 2007 figures. HRQoL was assessed using EuroQol-5D (EQ-5D) questionnaire and evaluated with Spanish Time Trade Off tariffs. Both costs and outcomes were assessed for each patient over the first 6-months of the PROCESS trial. **RESULTS:** The 6-month mean total health care cost in the SCS group (€17,291; SD €4.243) was significantly higher than in the CMM group (€1,433; SD€2,088), with a mean difference of €15,858 (95% CI: 14.548–17.173€). A reduction in drug costs for SCS group was observed. However, the gain in HRQoL with